BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

KEVIN R. PILE	)	
Claimant	)	
V.	)	
	)	
TEXTRON AVIATION, INC.	)	CS-00-0336-747
Respondent	)	AP-00-0444-835[1]
AND	)	
	)	
AMERICAN ZURICH INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant appealed the August 7, 2019, Award entered by Administrative Law Judge Thomas Klein. The Board heard oral argument on November 21, 2019. Mark Kolich of Lenexa, Kansas, was appointed by the Director as a Board Member Pro Tem in this matter.

APPEARANCES

Michael L. Snider of Wichita, Kansas, appeared for claimant. Brock J. Baxter of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulations are listed in the Award. The record also includes Dr. Jarron I. Tilghman's: (1) March 7, 2018, independent medical evaluation (IME) report; (2) September 17, 2018, IME report and (3) September 18, 2018, rating letter.

[1] Formerly Docket No. 1,081,995.

ISSUES

Judge Klein, for the residual disability from claimant's June 6, 2015, work injury, awarded claimant a 5 percent right upper extremity functional impairment at the level of the forearm under the *Guides* (6th ed.).[2]

At the regular hearing, claimant asserted that use of the *Guides* (6th ed.) is unconstitutional. In his brief to the Board, claimant requests the Board award him a 25 percent whole body functional impairment based upon the *Guides* (4th ed.)[3] for bilateral upper extremity injuries. In his reply brief to the Board, claimant contends the only competent evidence providing bilateral carpal tunnel syndrome ratings comporting with the *Guides* (6th ed.) requirements were provided by Dr. Pedro A. Murati. Claimant requests the findings of the judge be reversed as not complying with the *Guides* (6th ed.) and his award increased for his bilateral upper extremity impairments.

Respondent asserts the *Guides* (6th ed.) should be utilized in determining claimant's impairment and the 5 percent right upper extremity functional impairment awarded by Judge Klein should be affirmed. At the regular hearing, respondent did not dispute claimant sustained personal injury by repetitive trauma arising out of and in the course of his employment.

The issues are:

1. Is the use of the *Guides* (6th ed.) unconstitutional?

2. What is the nature and extent of claimant's disability?

FINDINGS OF FACT

Claimant testified that in June 2015, he experienced pain in his hands running up his arms and into his elbow. He stated some things at work caused his pain to worsen, but it "was really starting to be bad driving when I was driving."[4] Claimant was treated by Dr. David T. Gwyn. According to claimant, he was diagnosed with bilateral mild to moderate carpal tunnel syndrome (CTS). The doctor performed a right hand surgery which, in claimant's estimation, made his right hand worse. At the regular hearing, claimant was

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[2] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (6th ed.).

[3] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

[4] R.H. Trans. at 10.

asked what sensitivity he had in his right hand and he indicated that if he did not wear a glove on his right hand, he did not think he could function.

After recovering from surgery, claimant was released without work restrictions and returned to work for respondent. Claimant indicated he has numbness in the right hand and a feeling of needles in his palm and three middle fingers. Claimant was referred to Dr. J. Mark Melhorn, who recommended a second right hand surgery, which claimant refused.

At respondent's request, claimant saw Dr. Melhorn on September 21, 2017. Claimant complained of symptoms in his right hand, including his thumb and his index, middle and ring fingers on both the dorsal and palmar aspect. The doctor noted claimant underwent a right carpal tunnel release performed by Dr. Gwyn on September 3, 2015, and a repeat nerve study on February 23, 2017, demonstrated additional nerve changes. Claimant reported intermittent left upper extremity symptoms, but did not want treatment. The doctor indicated claimant had bilateral negative percussion, Phalen's, reverse, direct, pronator and Finkelstein's and noted that a June 24, 2015, nerve conduction test showed bilateral CTS, mild to moderate on the left and moderate to severe on the right. Dr. Melhorn's diagnoses were: (1) 6/14/2015, report right CTS and left CTS by history; (2) right[5] CTS surgery, 9/2/2015, by Dr. Gwyn; (3) 9/3/2015, swelling and painful with burning sensation in claimant's right index, middle and ring fingers; (4) painful right hand; and (5) neuropraxia, right and left.

Dr. Melhorn recommended physical therapy and, after claimant underwent said physical therapy, met with claimant again on October 12, 2017. At that visit, the doctor told claimant his options were to proceed with no treatment, do more physical therapy or undergo more surgery.

At Dr. Melhorn's request, claimant underwent bilateral nerve conduction testing on October 17, 2017. Dr. Melhorn indicated that on the left, claimant had some delay in nerve conduction velocity. In an October 19 note, the doctor stated that claimant had some progression with regard to nerve entrapment on the right and demonstrated increasing loss of function on the right.

Dr. Melhorn explained it is common for a person to have no symptoms of CTS, but have positive test results. In such situations, physicians do not routinely operate because the patient is asymptomatic. He went on to state that a diagnosis of CTS is based upon a complaint of symptoms that is supported by nerve conduction test results and physical examination.

[5] Dr. Melhorn's diagnoses indicate claimant's surgery was on the left, but it was on the right.

Dr. Melhorn met with claimant again on October 26 and November 16, 2017. Dr. Melhorn's notes from the October 26 visit stated claimant continued to have CTS symptoms, right and left. In his notes for claimant's last visit on November 16, the doctor indicated claimant had subjective disproportional complaints consistent with residual right CTS, but that his objective findings were not consistent with complex regional pain syndrome (CRPS) or reflex sympathetic dystrophy (RSD). At that visit, claimant wore a glove on his right hand and indicated he still had altered sensation on the dorsal and palmar aspects of the right hand.

At Dr. Melhorn's deposition, the parties placed into evidence results from the June 24, 2015, nerve conduction test of Dr. Calvin Olmstead and the October 17, 2017, nerve conduction test ordered by Dr. Melhorn. Both test results showed evidence of bilateral CTS. In his summary/interpretation of the 2017 test results, Dr. Melhorn stated: "1). Evidence of mild to moderate bilateral carpal tunnel syndrome. 2). No evidence of a peripheral neuropathy or plexopathy."[6]

On November 28, 2017, Dr. Melhorn, using Table 15-23 of the *Guides* (6th ed.), placed claimant in Grade Modifier 1 and assigned claimant a 2 percent right forearm functional impairment. Dr. Melhorn indicated that claimant's October 2017 nerve conduction test showed claimant has a nerve conduction delay. If he used the *Guides* (4th ed.), claimant would have a 2 to 10 percent right forearm functional impairment. The doctor stated he did not provide an impairment for claimant's left upper extremity. The doctor indicated claimant made no complaints of left hand symptoms, his clinical examination of claimant did not support a diagnosis of CTS and claimant had no left upper extremity functional impairment under the AMA *Guides* (6th ed.). The doctor stated that if he were to use the AMA *Guides* (4th ed.) to rate claimant's left upper extremity, he would have a 0 percent impairment.

At Dr. Melhorn's deposition, claimant placed into evidence, without objection, a letter from Dr. Gwyn stating claimant had a 3 percent right upper extremity functional impairment and no left upper extremity functional impairment. The judge did not reference Dr. Gwyn's rating when making his award, nor did the parties request that the Board consider Dr. Gwyn's impairment ratings.

Dr. Murati first evaluated claimant on December 12, 2017. Among claimant's chief complaints were pain, numbness and electrical shock sensations in his right hand and tingling in his left hand. During his physical examination of claimant, Dr. Murati noted claimant's right hand was cold compared to his left hand. The doctor also noted that claimant wore a glove. Dr. Murati's impressions were status post right open carpal tunnel release and right upper extremity CRPS. The doctor opined claimant's work activities were

[6] Melhorn Depo., Ex. 3.

the prevailing factor causing the development of his conditions. The doctor assigned restrictions and recommended additional treatment, but did not provide an impairment rating.

On January 25, 2018, Judge Klein requested an independent medical evaluation from Dr. Tilghman, "for the purpose of determining his opinion on a diagnosis and prevailing factor including treatment recommendations. Specifically the court is interested in an opinion that resolves the different diagnoses between other physicians."[7]

Claimant saw Dr. Tilghman on March 6, 2018. In his March 7, 2018, IME report, the doctor noted, "At this time, Mr. Pile is a 60-year-old right-handed Caucasian male who presents for evaluation of right hand and wrist discomfort, which occurred while participating in a vocational-related activity."[8] The doctor indicated claimant was diagnosed by other doctors with right CTS and right upper extremity CRPS.

Dr. Tilghman's report states that an October 17, 2017, nerve conduction test revealed evidence of mild to moderate bilateral CTS and a June 24, 2015, nerve conduction test revealed mild left and moderate right CTS. Ultimately, the doctor's impressions were pain in the right hand and wrist, neuralgia and neuritis affecting the right hand and wrist and status post right open carpal tunnel syndrome with resolution of preoperative symptoms. Dr. Tilghman stated claimant did not meet the criteria for CRPS. Interestingly, Dr. Tilghman stated in his report, "Regarding the clinical criteria, I utilized the AMA guides to the evaluation of disease and injury causation Second Edition, page 403, table 11-3."[9] However, at the bottom of his report, Dr. Tilghman stated he used the *Guides* (6th ed.).

Claimant was evaluated by Dr. Murati a second time on May 17, 2018. The doctor listed claimant's chief complaints in his report and specifically noted claimant had no current left hand complaints. Dr. Murati's impressions were the same as in December 2017, except he stated claimant also had left carpal tunnel syndrome. Using the AMA *Guides* (6th ed.), Dr. Murati testified claimant had an 8 percent right upper extremity functional impairment (5 percent whole person impairment) and an 8 percent left upper extremity functional impairment (5 percent whole person impairment) for a combined 10 percent whole person impairment. His rating did not include the 6 percent impairment for right upper extremity CRPS provided in his May 17, 2018, report. Dr. Murati testified that if he rated claimant using the *Guides* (4th ed.), claimant would have a 33 percent right upper extremity functional impairment (20 percent whole person impairment) and a

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[7] Judge's Order (Jan. 25, 2018).

[8] Tilghman IME Report (Mar. 7, 2018) at 1.

[9] *Id.* at 4.

10 percent left upper extremity functional impairment (6 percent whole person impairment) for a combined 25 percent whole person impairment.

Dr. Murati testified that CRPS, in layman's terms, means "it hurts a great deal."[10] He went on to explain that CRPS is usually caused by a trauma such as a surgical procedure by an orthopedic surgeon and in some cases can occur where there is no trauma. When asked how claimant's CRPS occurred, Dr. Murati testified:

> Well, it could have preceded the surgery. Just the crushing of the nerve, the median nerve at the wrist, can lead to it, but also the release itself. Now, mind you, this in no way is - what's the word I'm looking for - an expression of the quality of the surgeon. What's the word I'm looking for?
>
> . . .
>
> Hold on. This in no way reflects on the abilities of the surgeon. It just happens.
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> . . .
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> If the extreme pain came after surgery, then it would have been as a result of the surgery.[11]

At Dr. Murati's deposition, an article entitled "Complex Regional Pain Syndrome: Pathophysiology, Diagnosis, and Treatment," published on painmedicinennews.com was placed into evidence by claimant. Dr. Murati testified he would hold off on any further surgery until claimant's CRPS symptoms were controlled. The doctor testified that claimant had no discoloration of his right upper extremity, no dystrophic hair growth, no dystrophic nail growth, no edema and no sweat changes, but his right hand was cold, all of which are listed as symptoms of CRPS I or CRPS II in the aforementioned article.

Dr. Murati was asked to review the billing codes of Dr. Melhorn and confirmed that Dr. Melhorn's diagnostic codes on his billing statements included claimant's conditions as right CTS, right upper limb causalgia and left upper limb causalgia and one statement included left CTS. Dr. Murati explained that causalgia is the old name for CRPS II.

With regard to claimant's left upper extremity, Dr. Murati testified that when he saw claimant in 2017, he did not diagnose claimant with left CTS. The doctor agreed that a nerve conduction test showed claimant had mild to moderate left CTS. Dr. Murati testified that CTS is a clinical diagnosis and just because a study says a patient has CTS does not

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[10] Murati Depo. at 5.

[11] *Id.* at 6-7.

mean he/she really has it and that is why he did not diagnose it in his first evaluation. The doctor indicated he diagnosed left CTS in his second report because the CTS had time to develop as a result of claimant favoring his right upper extremity. Dr. Murati opined the prevailing factor causing claimant's bilateral CTS and right upper extremity CRPS was his work activity at respondent. He further stated that, "It all started with the right hand and then went to the left."[12] Dr. Murati acknowledged claimant had a negative left carpal compression examination at both evaluations. Dr. Murati recommended claimant use Celebrex for pain due to his conditions.

In an August 27, 2018, Order, the judge requested an independent medical evaluation from Dr. Tilghman "for the purpose of determining his opinion on a diagnosis, rating under the 4th and 6th edition to the Guides to the Evaluation of Permanent Impairment and a prevailing factor opinion."[13]

On September 17, 2018, claimant was again evaluated by Dr. Tilghman and the doctor issued a second IME report. The doctor's impressions at that evaluation were pain in the right wrist and hand, neuralgia and neuritis. The next day, Dr. Tilghman provided opinions regarding prevailing factor and claimant's functional impairment. The doctor's prevailing factor opinion remained unchanged – that claimant's work activity was the prevailing factor for his condition. Dr. Tilghman, using Table 15-23 at page 449 of the *Guides* (6th ed.), indicated claimant had a 5 percent right upper extremity functional impairment. The doctor indicated that using Figure 5 at page 3/22 and Table 11 at page 3/48 of *the Guides* (4th ed.), claimant had a 10 percent functional impairment. The doctor did not rate claimant's left upper extremity.

Lori Halsey, a case manager utilized by respondent, was deposed by claimant. Ms. Halsey indicated she had acquired a report of Dr. Chris D. Fevurly. Claimant offered into evidence, without objection, the notes and reports of Ms. Halsey; the June 7, 2017, report of Dr. Fevurly; and a medical record of Dr. Melhorn.

Dr. Fevurly evaluated claimant on June 7, 2017. Claimant complained that right hand gripping caused pain, numbness and tingling in his second, third and fourth fingers. Dr. Fevurly noted claimant had hypersensitivity to non-painful stimuli when contacting or brushing over the palmar surface of the right hand and producing burning dysesthesia into the three middle fingers. Dr. Fevurly diagnosed claimant with severe right CTS treated with surgery and causalgia versus CRPS II versus injury/entrapment of the common digital branch versus inadequate median nerve release. The doctor felt claimant had a poor right carpal tunnel release outcome. The doctor opined the prevailing factor for the development

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[12] *Id.* at 10.

[13] Judge's Order (Aug. 27, 2018).

of claimant's right CTS was his cumulative work duties that he performed for more than three decades.

Dr. Fevurly's report does not indicate claimant made any left hand complaints. The doctor indicated that provocative testing for bilateral CTS was normal. Although Dr. Fevurly had two prior nerve conduction reports, he does not state those reports were positive as to claimant's left upper extremity.

In a September 5, 2017, report, Ms. Halsey stated claimant was seen for a second opinion by Dr. John Estivo, who recommended a repeat nerve conduction test, which was completed on February 23, 2017. Ms. Halsey's September 2017 report indicated the results revealed claimant had moderate to severe right CTS and mild left CTS. The judge did not reference Drs. Fevurly or Estivo when making his award, nor did the parties request that the Board consider the records or opinions of Drs. Fevurly and Estivo.

The judge, with little explanation other than noting Dr. Tilghman was the neutral examiner, adopted the findings of Dr. Tilghman. The judge ruled claimant had a 5 percent right upper extremity functional impairment only.

PRINCIPLES OF LAW AND ANALYSIS

At the regular hearing, claimant asserted that use of the *Guides* (6th ed.) as required by K.S.A. 2014 Supp. 44-510e(a)(2)(B) is unconstitutional. The Board is not a court of proper jurisdiction to decide the constitutionality of laws in the state of Kansas. A statute is presumed constitutional.[14] The Board will utilize the *Guides* (6th ed.) as written until instructed otherwise by a court of competent jurisdiction.

Tovar[15] allows the Board to weigh the evidence and make its own conclusions as to an injured worker's functional impairment. In *Tovar*, one physician opined Tovar had a 15 percent functional impairment while others opined 2 percent. The district judge concluded Tovar sustained a 9 percent functional impairment. Tovar argued there was simply no evidence presented on which the district court could have based its finding of a 9 percent impairment. The Kansas Court of Appeals stated:

> The existence, nature, and extent of the disability of an injured worker is a question of fact. Medical testimony is not essential to the establishment of these facts. Thus, the district court, as the factfinder, is free to consider all of the evidence and decide for itself the percentage of disability. The numbers testified to by the physicians are not absolutely controlling.

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[14] *Baker v. List and Clark Construction Co.*, 222 Kan. 127, 563 P.2d 431 (1977).

[15] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, Syl. ¶ 1, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

This is an unusual case. The Board has often decided cases wherein an injured worker reported symptoms of a particular type of injury, but clinical testing did not support those symptoms. Rarely has the Board decided a case where the clinical tests showed the injured worker has an injury or condition, but it is asserted that because they have little or no symptoms, there is no work injury and/or permanent disability. In the present case, claimant underwent three nerve conduction tests. The evidence is that the June 2015 and October 2017 test results showed claimant had evidence of left CTS. Yet, Drs. Melhorn and Murati indicated there must be more than a positive nerve conduction test for claimant to have CTS; the patient must also have symptoms of CTS.

The Board gave a great deal of thought as to whether the reports of Drs. Gwyn and Fevurly are part of the record. As noted above, the reports of those doctors were offered into evidence without objection. K.S.A. 44-519 provides that no report of an examination of an employee by a health care provider is competent evidence unless the health care provider issuing the report testifies. However, this statute has been skirted in several ways.

In *Boeing*,[16] the Kansas Workers Compensation Fund (Fund) objected to the testimony of two physicians whose medical opinions were based, in part, on Enloe's past medical records. Because the doctors generating the past medical records did not testify at the proceeding, the Fund claimed the records were inadmissible under K.S.A. 44-519. The Kansas Court of Appeals found that K.S.A. 44-519 "literally applies only when a party seeks to introduce a report or certificate of a physician or surgeon into evidence."[17] In *Boeing*, Enloe did not attempt to introduce the past medical records into evidence. The Kansas Court of Appeals ruled, "K.S.A. 44-519 does not prevent a testifying physician from considering medical evidence generated by other absent physicians as long as the testifying physician is expressing his or her own opinion rather than the opinion of the absent physician."[18]

In the present case, *Boeing* is not applicable. Dr. Gwyn's report is, in essence, a one-page letter with his impairment rating opinion. There is insufficient evidence that Dr. Melhorn, at whose deposition Dr. Gwyn's report was placed into evidence, relied on Dr. Gwyn's report. Dr. Fevurly's report was placed into evidence during the deposition of a case manager.

Second, K.A.R. 51-3-5a(a) allows parties to stipulate medical records into evidence, even where the health care provider did not testify. While placing something into evidence

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[16] *Boeing Military Airplane Co. v. Enloe*, 13 Kan. App. 2d 128, 764 P.2d 462 (1988), *rev. denied* 244 Kan. 736 (1989).

[17] *Id.* at 130.

[18] *Id.*, Syl. ¶ 3.

without objection is not the equivalent of a written stipulation, it is sufficiently akin to a stipulation for the Board to allow the reports of Drs. Gwyn and Fevurly into the record. Since there was no objection to the reports/records of Drs. Gwyn and Fevurly, the Board infers the parties intended they be part of the record. Moreover, K.S.A. 2014 Supp. 44-523(a) states neither the judge nor the Board shall be bound by technical rules of procedure and the parties shall be given reasonable opportunity to be heard and present evidence.

The Board finds claimant sustained a left CTS injury by repetitive trauma that arose out of and in the course of his employment. Specifically, the Board concludes claimant's repetitive work activity was the prevailing factor causing his injury, need for medical treatment and resulting disability. Dr. Melhorn's notes of October 26, 2017, indicated claimant reported symptoms of left CTS. Moreover, Dr. Murati diagnosed claimant with left CTS.

From the judge's orders appointing Dr. Tilghman to evaluate claimant, it is uncertain if Dr. Tilghman was asked to evaluate claimant's left upper extremity. The doctor was largely silent on whether claimant had left CTS, other than to state the nerve conduction tests revealed CTS. Dr. Tilghman was also silent on whether claimant had a left upper extremity functional impairment, which is different than stating claimant had no left upper extremity functional impairment rating.

Although Dr. Gwyn opined claimant had no permanent left upper extremity functional impairment, the Board gives it little weight. The judge only briefly mentioned Dr. Gwyn in the Award and did not consider Dr. Gwyn's rating. The parties, in their briefs and at oral argument, did not ask the Board to consider Dr. Gwyn's ratings. Dr. Gwyn stated claimant had no left upper extremity impairment but provided little explanation as to how he arrived at his opinion, even though he treated claimant's left upper extremity conservatively.

The next issue is whether claimant has right upper extremity causalgia, or CRPS II. Drs. Murati and Fevurly diagnosed claimant with this malady. However, Dr. Murati later indicated that claimant had no functional impairment for right upper extremity CRPS. Thus, the majority of the doctors who evaluated claimant opined he either did not have right upper extremity CRPS II or he had no functional impairment for that condition. Consequently, the Board finds claimant sustained no right upper extremity functional impairment for CRPS II.

Determining claimant's left and right upper extremity functional impairment is a difficult and daunting task, due to the divergent opinions of the experts. Dr. Murati's 8 percent left upper extremity impairment rating is excessive, if one looks at Table 15-23, which is the table Dr. Murati used to evaluate claimant. An 8 percent places claimant in Grade Modifier 3. Grade Modifier 3 requires a test finding that claimant had axon loss, a

history of constant symptoms and atrophy or weakness. Claimant did not report having constant symptoms and nerve conduction testing showed a conduction delay.

Dr. Melhorn's opinion that claimant had no left upper extremity functional impairment is based on the premise that claimant had no left CTS, a premise which the Board has rejected. In order for claimant to be in Grade Modifier 0 of Table 15-23, he would have a normal nerve conduction test result, have a history of mild intermittent symptoms and have normal physical findings. Therefore, the Board chooses to average the ratings of Drs. Murati and Melhorn and find claimant sustained a 4 percent functional impairment to the left upper extremity for left CTS.

With respect to claimant's right upper extremity, the Board notes the 2 percent functional impairment rating of Dr. Melhorn places claimant in Grade Modifier 1. A person in Grade Modifier 1 has a nerve conduction test finding of conduction delay, a history of mild intermittent symptoms and normal physical findings.

Dr. Tilghman's 5 percent rating places claimant in Grade Modifier 2. A person in Grade Modifier 2 has test findings of motor conduction block, a history of significant intermittent symptoms and physical findings of decreased sensation.

Dr. Murati's 8 percent right upper extremity rating places claimant in Grade Modifier 3. As indicated above, for a person to be in Grade Modifier 3, they must have test results of axon loss, a history of constant symptoms and physical findings of atrophy or weakness.

The evidence is that claimant does not neatly fit into any of the grade modifiers. Claimant's nerve conduction results of conduction delay would place him in Grade Modifier 1; his history of ongoing symptoms would place him in Grade Modifier 2 or 3 and his physical findings would place him in Grade Modifier 2 or 3. The Board finds the evidence is that claimant is either in Grade Modifier 2 or 3. Therefore, the Board will average the 5 percent rating of Dr. Tilghman with Dr. Murati's 8 percent rating for a 6.5 percent right upper extremity functional impairment for right CTS. The Board also notes that claimant's left CTS is mild to moderate and his right CTS is moderate to severe. Claimant's right upper extremity symptoms are much more severe than his left upper extremity symptoms.

Using Table 15-11 of the *Guides* (6th ed.), claimant's 4 percent left upper extremity functional impairment converts to a 2 percent whole person functional impairment and his 6.5 percent (rounded to 7 percent) right upper extremity functional impairment converts to a 4 percent whole person functional impairment. Then, using the Combined Values Chart, claimant has a 6 percent whole person functional impairment.

CONCLUSION

1. The Board does not have jurisdiction to determine if the *Guides* (6th ed.) is unconstitutional.

2. Claimant has a 6 percent whole body functional impairment.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[19] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

AWARD

WHEREFORE, the Board modifies the August 7, 2019, Award entered by Judge Klein by finding claimant is entitled to 24.90 weeks of permanent partial disability benefits at the rate of $594 per week, or $14,790.60, for a 6 percent whole body functional impairment and a total award of $14,790.60, which is all due and owing, less any amounts previously paid. The remainder of the Award is affirmed.

IT IS SO ORDERED.

Dated this ____ day of February, 2020.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER PRO TEM

[19] K.S.A. 2018 Supp. 44-555c(j).

DISSENT

The undersigned have many concerns about the Board's decision. The Board makes the following assertions:

- "[I]t is uncertain if Dr. Tilghman was asked to evaluate claimant's left upper extremity."

- Dr. Tilghman was "largely silent on whether claimant had left CTS . . ." and "silent on whether claimant had a left upper extremity functional impairment . . . ."

- "Dr. Fevurly's report does not indicate claimant made any left hand complaints."[20]

Our first concern is that the majority somehow equates the absence of medical commentary about the claimant's left upper extremity as justification to find impairment involving his left hand and wrist. The ruling is counterintuitive.

The majority's suggestion that Dr. Tilghman was not asked to address the possibility of left arm impairment is unwarranted. The judge issued an open-ended request to Dr. Tilghman to diagnose the claimant's condition and provide his opinion regarding impairment of function. We should not pretend Dr. Tilghman was limited to only address the claimant's right arm, hand, wrist and fingers or told to ignore any possibility of impairment of the claimant's left upper extremity.

There is a reason for the absence of left upper extremity complaints in most of the medical reports: the claimant generally did not voice concerns about his left arm, hand, wrist or fingers. Dr. Fevurly specifically indicated the claimant complained about pain, numbness and tingling in his right hand and fingers, *but that the claimant specifically did not have the symptoms in his left hand*. It is nonsense for a doctor to evaluate a body part for which an injured worker is not voicing complaints. Only the squeaky wheel gets the grease.

Second, the Board partially ignored or needlessly discredited opinions from a treating doctor, Dr. Melhorn, and a court-ordered physician, Dr. Tilghman. The Board has

[20] At Dr. Murati's October 22, 2018 deposition, the respondent objected to Dr. Fevurly's report coming into evidence as hearsay. However, the report was already in evidence because it was offered into evidence without objection at Lori Halsey's January 19, 2018 deposition.

historically given some deference to the opinions of treating physicians[21] and court-ordered and neutral physicians.[22] The Board must consider a court-ordered IME's report under K.S.A. 2014 Supp. 44-516.[23]

The Board excluded Dr. Tilghman's opinion with respect to impairment for left CTS. The lack of a rating does not mean Dr. Tilghman ignored any of the claimant's complaints and it certainly does not mean that claimant has impairment due to left CTS. Simply put, the claimant did not complain to Dr. Tilghman about his left arm, hand, wrist or fingers. At his March 7, 2018 evaluation, the claimant complained to Dr. Tilghman about "right hand and wrist discomfort."[24] The claimant also complained about bilateral upper extremity numbness that did not affect his job performance, but reiterated having right upper extremity pain. The doctor was aware of EMG/NCS showing evidence of mild left CTS. Nevertheless, he only diagnosed pain, neuralgia and neuritis in claimant's right hand and wrist. At a return visit on September 17, 2018, the claimant denied "any new symptoms or involvement beyond the confines of the right hand and wrist."[25] Dr. Tilghman's diagnoses remained the same, i.e., *involving the right hand and wrist only*. We see little reason to discount or disregard Dr. Tilghman's opinions. This opinion is not based on simple speculation. The majority opinion seemingly (and needlessly) requires a doctor to examine and rate a condition for which the claimant did not complain.

The opinion of Dr. Melhorn, a treating physician, that the claimant has a 2% right forearm rating is not included in the Board's computations. Dr. Melhorn, through his testimony and records, primarily examined and treated the claimant for a painful right hand and wrist. Dr. Melhorn is an orthopedic surgeon and an upper extremity specialist. He teaches at the University of Kansas School of Medicine. The doctor has assisted in developing the 4th, 5th and 6th Editions of the AMA *Guides*, particularly concerning the upper extremities.

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[21] See *Nasi v. Jimmy's Egg*, No. 1,067,478, 2017 WL 898263, at *15 (Kan. WCAB Feb. 9, 2017). The Court of Appeals has indicated it is "unfortunate when the parties elect to abandon the opinions of the treating physicians, instead presenting evidence from hired independent medical examiners." *Durham v. Cessna Aircraft Co.*, No. 196,986 (Kan. WCAB Aug. 1996); *aff'd* 24 Kan. App. 2d 334, 945 P.2d 8, *rev. denied* 263 Kan. 885 (1997).

[22] See *Nasi v. Jimmy's Egg*, No. 1,067,478, 2017 WL 898263, at *15 (Kan. WCAB Feb. 9, 2017).

[23] See *Alaniz v. Dillon Cos., Inc.*, No. 109,784, 2014 WL 3731939, at *9 (Kansas Court of Appeals unpublished opinion filed July 25, 2014).

[24] Dr. Tilghman's Mar. 7, 2018 report at 1.

[25] Dr. Tilghman's Sept. 17, 2018 report at 1.

At the claimant's September 21, 2017 visit with Dr. Melhorn, his listed symptoms were right hand hypersensitivity involving his three middle fingers and his palm, the inability to feel things and a constant, burning, electrical shock pain. The claimant's pain drawing only demonstrated right hand and finger symptoms. The claimant told Dr. Melhorn he had right hand and finger pain, numbness and a burning, electric shock pain. The claimant only reported intermittent symptoms, such as swelling, for his left upper extremity and did not want any medical treatment for the left side. Physical examination revealed right hand and wrist tenderness. Some testing was positive for left-sided symptoms, but not diagnostic. Dr. Melhorn diagnosed a painful right hand and bilateral neuropraxia and noted a right carpal tunnel syndrome diagnosis was reasonable.

The claimant's October 12, 2017 pain drawing only noted right hand and finger symptoms. A circle on the left hand is crossed-out. Dr. Melhorn wanted a NCT to compare the upper extremities. At an October 26, 2017 visit, Dr. Melhorn noted the claimant had CTS symptoms on the left and right and residual symptoms on the right side. Using the term "residual" for the right side only implies there was no left-sided "residual."

At their November 16, 2017 visit, Dr. Melhorn noted the claimant continued to complain of residual symptoms in his right index, middle and ring fingers. The doctor continued to diagnose right CTS, but nothing on the left side.

Dr. Melhorn's rating report indicated the claimant's diagnosis was right wrist CTS. The 2% impairment rating he provided is based on the standard value in table 15-23, which has categories for test findings, history or physical findings. There is nothing to suggest Dr. Melhorn used the table incorrectly. The doctor's records suggest the claimant has nerve conduction delay of his right upper extremity (but not motor conduction block, axon loss or almost a dead nerve for higher grade modifiers), mild intermittent symptoms (not significant intermittent or constant symptoms needed for higher grade modifiers) and some hand numbness (but no atrophy or weakness needed for grade modifier 3).

Dr. Melhorn concluded the claimant did not have permanent impairment stemming from left CTS, despite positive nerve conduction testing. The majority cites table 15-23 to say the only way to get a 0% rating on the left would be if the claimant had a normal EMG/NCT. That is inaccurate. There is no evidence in the record saying a positive nerve conduction study requires an impairment rating. Table 15-23 does not explain how ratings are arrived at under the *Guides*. As testified to by Dr. Melhorn, a rating depends on more than just a nerve conduction study, but must account for a patient's history and the doctor's physical examination. The Board ignores the possibility that the *Guides* require grade modifiers for different categories be averaged or that a rating is based on the whole picture. Also, under the Board's stance, if the claimant does not have something like motor conduction block, he would be ineligible to qualify for the higher grade modifiers. Absent obvious error, the ratings are best left to doctors and effective cross-examination, not the Board's imperfect understanding of the *Guides*.

Third, the Board downplays or ignores the impact of the report from Dr. Gwyn, another treating physician, but concedes such report was admitted into evidence without objection.[26] Dr. Gwyn's report states he treated the claimant for bilateral carpal tunnel syndrome, with the right side needing surgery, but the left side only necessitating conservative treatment. The doctor rated the claimant's impairment at 3% to the right upper extremity, but he specifically opined the claimant had *no left-sided impairment for CTS*.

The Board notes the judge did not address Dr. Gwyn's rating and the parties did not ask the Board to look at such rating. These considerations are of little consequence. The bottom line is the report was offered into evidence without objection. It is part of the evidence, especially in the more relaxed evidentiary standards of a workers compensation proceeding.[27] Dr. Gwyn indicated the claimant had no left upper extremity impairment because that was his opinion. An in-depth explanation is not required; it is just an excuse for the majority to ignore this evidence.

Fourth, the Board places too much weight in the opinions of Dr. Murati, who examined the claimant twice at the request of his counsel. *On both occasions, the doctor's physical examination of claimant for carpal compression on the left side was negative.* The doctor's December 12, 2017 report lists six chief complaints involving the claimant's right hand and, lastly, a solitary complaint of tingling affecting the left hand. Dr. Murati's impressions were status-post right carpal tunnel release and right upper extremity CRPS. While the doctor noted repetitive trauma to both upper extremities that caused complaints, no left-sided diagnosis was provided. On page nine of his deposition, Dr. Murati testified that despite nerve testing showing mild left CTS, the study is not determinative and he did not believe the claimant had clinical left CTS. Dr. Murati's downplaying the mild nerve conduction study is consistent with Dr. Melhorn's testimony.

Dr. Murati's May 17, 2018 report specifically stated the claimant had "[n]o current left hand complaints."[28] Nevertheless, Dr. Murati diagnosed left CTS because the claimant, over time, was overusing his left hand from favoring his right hand. It is curious to find impairment for left CTS in the absence of complaints and a normal physical examination.

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[26] Medical records offered into evidence without objection are routinely considered part of the record. See *Cox v. City of Pratt*, No. 1,065,334, 2015 WL 996901 (Kan. WCAB Feb. 17, 2015); *Wolters v. City of St. Francis*, No. 1,054,900, 2014 WL 6863028 (Kan. WCAB Nov. 25, 2014); *aff'd* No. 112,947, 2016 WL 562918 (Court of Appeals unpublished opinion filed Feb. 12, 2016). The admissibility of evidence is "'more liberal in compensation cases' than in court cases." *Woessner v. Labor Max Staffing*, 56 Kan. App. 2d 780, 791, 437 P.3d 992 (2019), *rev. granted* (Sept. 5, 2019).

[27] "[A]dministrative proceedings are streamlined to strike a balance between strictly following all the evidentiary rules and allowing just about anything to be considered." *Woessner*, 56 Kan. App. 2d at 792.

[28] Murati Depo., Ex. 3 at 1.

Fifth, functional impairment as defined in K.S.A. 2014 Supp. 44-508(u), is "the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence . . . ." This definition is similar to occupational impairment contained in the AMA *Guides*, 6th Ed.: "Impairment" is "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease."[29] Apart from Dr. Murati, no doctor rated the claimant's left upper extremity. Dr. Murati's examination of the claimant's left arm was basically normal. Where is the loss of physical function or the decrease in physiological capabilities?

Sixth, the Board provides no citations for the broad-brush proposition that we rarely decline to award permanent disability benefits in situations where a worker has a positive clinical test, but has little or no symptoms. The opposite is accurate. Impairment requires loss of physiological function. A verifiable and objective condition may be diagnosed, but the existence of a diagnosis does not mean there is impairment. For instance, a worker with an asymptomatic preexisting condition that does not actually impair him or her does not have preexisting impairment.[30] Here, the medical testimony suggests permanent impairment should not be based on a positive EMG/NCS alone.

Seventh, Dr. Melhorn's office simply listing codes on a medical bill for bilateral CTS does not mean claimant had rateable impairment for left CTS.

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[29] AMA *Guides*, 6th Ed., p. 5.

[30] See *Rogers v. ALT-A&M JV LLC*, No. 1,053,980, 2014 WL 7521733, at *12 (Kan. WCAB Apr. 12, 2014); *aff'd in part and denied in part* 52 Kan. App. 2d 213, 364 P.3d 1206 (2015) (evidence showing no loss of a portion of the total physiological capabilities of the human body weighed against a finding of preexisting impairment); *Shepard v. LaForge & Budd Constr. Co., Inc.*, No. 1,060,203, 2013 WL 5983244, at *8 (Kan. WCAB Oct. 3, 2013) (despite prior neck surgery, a worker had no loss of physiological capabilities and no preexisting impairment); *Miller v. Catholic Charity Community Service*, No. 1,042,450, 2011 WL 6122908, at *11 (Kan. WCAB Nov. 16, 2011); *aff'd* No. 107,105, 2012 WL 3630288 (Court of Appeals unpublished opinion filed Aug. 17, 2012) (a worker's degenerative disc disease predated her work-related accident, but she had no preexisting impairment because she was previously able to work without restrictions or accommodations before her work injury); *Jarrett v. Oasis Outsourcing, Inc.*, No. 1,041,652, 2010 WL 517327 (Kan. WCAB Jan. 8, 2010) (a prior neck surgery that caused no residual symptoms, pain, numbness or lost range of motion or inability to perform work was not a preexisting impairment); *Cowan v. U.S.D. No. 500*, No. 1,000,625, 2004 WL 2093569, at *4 (Kan. WCAB Aug. 23, 2004) (x-rays showed a preexisting degenerative knee condition, but it was not a preexisting impairment because the worker was previously asymptomatic); *Swonger v. Wichita Specialty Hospital*, No. 1,006,971, 2004 WL 1067477, at *2 (Kan. WCAB Apr. 27, 2004) (a worker's documented history of low back pain and treatment was not a preexisting impairment because she did not have a history of extensive time lost from work, inability to perform her normal activities or symptoms that did not resolve); *Watts v. Pavers, Inc.*, No. 217,530, 1998 WL 304288, at *1 (Kan. WCAB May 27, 1998) (preexisting spondylolisthesis that was undiagnosed, asymptomatic and necessitated no restrictions was not an impairment); cf. *Robles v. National Beef Packing Co., L.P.*, No. 242,197, 2001 WL 1725699, at *3 (Kan. WCAB Dec. 19, 2001) (preexisting degenerative disc disease most likely caused lumbar range of motion deficits was actually a preexisting impairment).

In summary, Dr. Melhorn rated the claimant's right forearm, but indicated there was no left-sided impairment. Dr. Tilghman only rated the claimant's right arm, but not the left. There is no support for the majority's baseless theory that perhaps Dr. Tilghman was precluded from addressing left-sided impairment. The absence of a left-sided rating from Dr. Tilghman, when the judge posed him an open-ended question to address the claimant's impairment rating, implies no such impairment. Dr. Gwyn's opinions are consistent with the right-sided ratings (and lack of left-sided ratings) provided by Drs. Melhorn and Tilghman. The claimant made no left-sided complaints to Dr. Fevurly. The outlier is Dr. Murati, who rated the claimant's left side despite a normal physical examination and his agreement that a nerve conduction study is not determinative. The lack of left hand and wrist complaints and a negative physical examination, despite objective testing showing mild left CTS, does not make for a finding that the claimant has permanent impairment of his left upper extremity.

We would average the right upper extremity ratings at 5% (Dr. Melhorn's 2% + Dr. Gwyn's 3% + Dr. Tilghman's 5% + Dr. Murati's 8% = 18% ÷ 4 = 4.5%, rounded up to 5%). Based on the preponderance of the medical records and opinions, the lack of proof of loss of left-sided physiological capabilities, and despite testing showing mild left CTS, we would find the claimant proved no impairment for his left upper extremity.

BOARD MEMBER

BOARD MEMBER

c: Michael L. Snider, Attorney for Claimant (via OSCAR)

P. Kelly Donley and Brock J. Baxter, Attorneys for Respondent and its Insurance Carrier (via OSCAR)

Honorable Thomas Klein, Administrative Law Judge